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Mental Health Among Persons Awaiting an Asylum Outcome in Western Countries: A Literature Review

Author(s): Dermot A. Ryan, Fiona E. Kelly and Brendan D. Kelly

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DERMOT A. RYAN, FIONA E. KELLY, AND
BRENDAN D. KELLY

# Mental Health Among Persons Awaiting an Asylum Outcome in Western Countries

## A Literature Review

ABSTRACT: *Asylum seekers are among the most marginalized and powerless groups in Western societies. Unlike persons with refugee status, asylum seekers live with the constant fear of deportation. They are generally denied access to work, private accommodation, education, and regular social welfare benefits. These harsh postmigration living conditions place asylum seekers at risk for poor mental health. This article reviews the empirical literature on asylum seeker mental health from the last 20 years. It focuses on nondetained adults awaiting an asylum outcome in Western countries. Twenty-three studies reported data for 7,294 asylum seekers. Overall, reports of psychological distress levels and prevalence rates of mental disorder were very high. This risk for poor mental health can be reduced by appropriate changes to the asylum procedure and social policy.*

In recent decades, many Western countries have experienced a rise in the number of persons lodging applications for political asylum after arriving in the host society. Most of the forced migrants who fled to Western countries before the 1990s were recognized as refugees before their arrival through a screening a process. In the 1980s, 2.3 million asylum applications were lodged in 37 industrialized countries [1]. In the 1990s, the total number of applications submitted in the same countries

Dermot A. Ryan, PhD, is a Post-Doctoral Researcher in Psycho-Oncology at the School of Nursing, Dublin City University, Dublin, Ireland. Fiona E. Kelly, BA, is PhD candidate at the School of Psychology, University College Dublin, Ireland. Brendan D. Kelly, MD, is a Consultant Psychiatrist at the Department of Adult Psychiatry, Mater Misericordiae Hospital, Dublin, and a Senior Lecturer in Psychiatry at the School of Medicine, University College, Dublin.



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was 6.1 million—almost a threefold increase on the previous decade. A striking example of the rise in numbers of asylum seekers was the situation in Ireland, where the total annual number of applications rose from 39 in 1992 to 11,634 in 2002 [2].

At a global level, the number of asylum applications reached its peak in 2000, with a total of 927,464 cases [3]. Since then, applications have declined. A total of 503,000 new asylum applications were lodged in 2006 [4]. Despite the downward trend, the total number of new and undecided cases represents a substantial underclass throughout the Western world.

The 1951 United Nations (UN) Geneva Convention [5] defined a refugee as a person who

> owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his [or her] nationality and is unable or, owing to such fear, is unwilling to avail himself [or herself] of the protection of that country. [p. 16]

An asylum seeker is a person who seeks protection under the UN convention after entering a country either on a temporary visa or without documents. The asylum process is an adversarial one in which the burden of proof lies with the applicant and it can take years to reach an outcome. If the applicant receives a negative outcome, he or she can face deportation.

Although the right to seek asylum is enshrined in international law, Western states have sought to curb the numbers of persons exercising this right by adopting a range of policies of deterrence [6]. These policies include stricter border controls and the imposition of fines on carriers of asylum seekers [7]. Ireland, for example, operates a system of direct provision whereby asylum seekers are excluded from normal social welfare benefits and from accessing private accommodation. Asylum seekers are dispersed throughout the country to accommodation centers where they are given full board and a weekly allowance of $27.25 (and $13.70 per dependant child). They are not allowed to work, access education beyond the age of 18, or travel outside the state. A number of countries have resorted to policies of detention for certain categories of asylum seekers, such as those who arrive without any documents [7–10].

Asylum seekers in Western societies today encounter conditions that are less favorable than those met by previous waves of forced migrants [11]. Suárez-Orozco and Suárez-Orozco emphasized the importance of the ethos of reception in relation to the well-being of immigrants [12]. In many Western countries, asylum seekers encounter an ethos of rejection by the host society. An analysis of the representation of asylum seekers in the Irish media found that they are associated with "scam artists, criminal gangs, spongers, rapists and murderers" [13, p. 187]. This combination of legal status insecurity, state restrictions on personal freedoms, a lack of validation of premigration difficulties, and hostility from the host society is a potent recipe for psychological suffering. This paper examines this risk through a

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review of studies that examine the postmigration mental health of persons awaiting an asylum outcome in Western countries.

Previous reviews of the literature on forced migrant mental health have focused on persons with refugee status [e.g., 14–16] or have examined asylum seekers and refugees together [17]. The only international review to focus on asylum seeker mental health is a paper by Silove, Steel, and Watters [6]. It was published in 2000 and, at the time, the authors acknowledged that research among asylum seekers was in its infancy. While the body of research on asylum seeker mental health is still small, there have been some notable additions to the literature since 2000.

There has also been a recent review of research on detained asylum seekers in Australia [7]. Given that most of the research among detained asylum seekers has been conducted in Australia and that the authors also summarized relevant international studies, this paper focuses on research among nondetained asylum seekers. It is not our intention here to underplay the importance of examining the mental health of detained asylum seekers. Indeed, the levels of psychological distress reported by a sample of 70 detained asylum seekers in the United States are among the highest found in any group of nonhelp-seeking forced migrants, with 86 percent reporting severe levels of depressive symptoms [9]. The noxious psychological impact of detention among asylum seekers is likely to be so strong that meaningful comparisons between detained and nondetained groups are problematic.

This review examines the postmigration mental health of nondetained adults who are awaiting an asylum outcome in Western countries. It examines both the levels and predictors of psychological well-being among this population.

## Method

The material included in the review was located primarily through computerized searches of the PsycINFO, MEDLINE and PubMed databases for the 20-year period from January 1, 1988 to December 31, 2007. Searches were confined to English-language studies. The terms used in the search of titles, abstracts, and keywords were "asylum seek*" and "asylum-seek*." The abstracts of each potentially relevant article were examined. Copies of all relevant articles were obtained, and their reference lists were searched manually to identify additional studies.

The review included studies that examined mental health among nondetained adult asylum seekers who had sought asylum in Western countries and were still in the asylum process at the time of the study. There were difficulties in identifying studies of persons still in the asylum process because (a) some studies did not give explicit details of the legal status of their samples [18] and (b) there were divergences in the use of the terms *refugee* and *asylum seeker*. In some studies, persons with refugee status were referred to as asylum seekers [19], while in others, persons still awaiting an asylum outcome were referred to as refugees [20].

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To be included in the review, a study had to report at least one empirical finding (qualitative or quantitative) in relation to the postmigration mental health of asylum seekers. Studies of refugees and asylum seekers were included as long as they provided at least one separate finding for each legal status category or a comparison of risk between each one. Four studies that included asylum seekers were excluded because they did not provide separate findings [21–24]. We made two exceptions to this requirement because most of the participants in the full sample (23 out of 26 [25]) or a subsample (48 out of 50 [26]) were asylum seekers. Studies that included both adults and children were included if they provided separate analyses for adults. Because of the smaller amount of studies on asylum seekers, we did not use the stricter inclusion criteria of previous reviews of forced migrant research, such as the inclusion of studies with nonrefugee comparison groups [17] or interview-based studies among community populations [14].

## Results

### *Methodological Characteristics*

Twenty-three studies met the inclusion criteria. Two of these reported findings on separate populations of asylum seekers [27–28]. In total, the studies provided data for 7,294 adult asylum seekers. This figure excludes samples or subsamples in which refugees and asylum seekers were grouped together (apart from the previously noted exceptions in which a significant majority of mixed legal status groups were asylum seekers). It also excludes a subsample of children in one study [29]. Twelve studies focused on non–help-seeking populations ($N = 1,919$), and nine focused on help-seeking populations ($N = 4,526$). Two studies included separate samples of non–help-seeking ($N = 648$) and help-seeking asylum seekers ($N = 201$) [27–28]. Hence, 29 percent ($N = 2,120$) of the data were from non–help-seeking populations, and the remaining 71 percent ($N = 5,174$) were from help–seeking populations.

Over three-fourths (78 percent) of the studies were conducted in Europe. The countries and number of studies are as follows: Austria (1), Denmark (2), Finland (1), Ireland (4), the Netherlands (3), Norway (1), Switzerland (3), and the United Kingdom (3). The remaining studies were conducted in Australia (4) and the United States (1). Regarding region of origin, 20 of the 23 studies give details for either the full sample or the major national or regional groups within the sample. From the data that are available for 2,324 asylum seekers, the Middle East ($N = 793$) and Africa ($N = 735$) are the best-represented regions. These are followed by Eastern Europe and the former Soviet Union ($N = 449$) and Asia ($N = 338$).

Details of gender are available for 2,435 asylum seekers. Of these, 60 percent ($N = 1,459$) were men and 40 percent ($N = 976$) were women. Thirteen of the studies provide mean ages ($N = 1,343$). The weighted mean age of these samples

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is 32.0 years. Eleven studies reported the mean length of stay in the host country. These values ranged from approximately two weeks to just over five and a half years.

In terms of data collection methods, most of the available data (72 percent) on asylum seekers is from analyses of records from various health services. Nine studies ($N = 5,216$) used such analyses. Given that one of these studies had a very large sample size ($N = 3,960$), over half (54 percent) of the data on asylum seekers come from a single study of clinical records in Denmark [30]. Most of the remaining studies involved face-to-face data collection ($N = 15$), with one study using a postal survey [31]. Only two of these studies used random sampling methods [32–34]. Most of the studies ($N = 19$; 83 percent) had a quantitative focus. There were three qualitative studies [25, 35–36] and one mixed-methods study [37].

Two studies focused on the validation of instruments. One examined the validity of a structured diagnostic interview in screening for major depression and post-traumatic stress disorder (PTSD) among asylum seekers [18]. The other examined the validity of a range of instruments in detecting traumatic symptoms among refugees and asylum seekers [26].

There are only two longitudinal studies of asylum seekers at an international level. One was conducted among a sample of detained asylum seekers in the United States [9]. It was not included here because the asylum seekers were in detention. Hence, only one longitudinal study was included [38–39].

### *Prevalence Rates: Non–help-Seeking Populations*

#### *Depression*

Eight studies among non–help-seeking populations report depression rates. These ranged from 9 percent to 69 percent. Using the Mini International Neuropsychiatric Interview (MINI), Eytan, Durieux-Paillard, Whitaker-Clinch, Loutan, and Bovier [20] found high levels of depression among asylum seekers from Europe, Africa and Asia. Almost half the sample (49 percent) reported depressed mood, and 30 percent met the criteria for major depression. In the same study, 34 percent received diagnoses of major depression by clinical experts. A similar rate of depression was observed among Iraqi asylum seekers in the Netherlands [33]. Using the Composite International Diagnostic Interview (CIDI), Laban, Gernaat, Komproe, Schreuders, and De Jong [33] found a lifetime prevalence of depressive disorder of 34.7 percent. This rate was significantly higher among asylum seekers who had been in the country for over two years (43.7 percent) versus less than six months (25.2 percent). See Table 1 for a summary.

Three studies used the Hopkins Symptom Checklist-25 (HSCL-25), which includes 15 depression items. The percentage scoring above the depression cut-off score were 33.3 percent in Australia [40], 47 percent in Ireland [41], and 61.5 percent in the Netherlands [32]. The Dutch study was the strongest methodologi-

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cally because it used random sampling among a relatively large group of asylum seekers ($N = 232$). In the other studies, small convenience samples were used ($N = 40$ and 43).

Blackwell, Holden, and Tregoning [42] developed a health questionnaire for dispersed asylum seekers in the north of England. In a sample of 397 asylum seekers, 18.9 percent reported symptoms of depression. Another study from the north of England interviewed a consecutive sample of 122 asylum seekers just after their arrival in the area [28]. In a clinical assessment, 9 percent had a diagnosis of depression. In a qualitative study of 10 asylum-seeking families in Finland, Sourander [29] used a semistructured interview to inquire about psychological symptoms in the previous two weeks. Eleven out of 16 (69 percent) parents reported depressed mood.

*Anxiety*

Five studies report findings in relation to anxiety among nonhelp-seeking asylum seekers. Using the CIDI, Laban et al. found a lifetime prevalence for anxiety disorders of 22.4 percent [33]. The rate was over twice as high among longer-staying (>2 years) asylum seekers (30.5 percent) versus those who had arrived in the previous six months (14.0 percent). In the full sample, 6.8 percent had generalized anxiety disorder (GAD). Studies in three countries reported anxiety prevalence rates based on HSCL-25 scores (10 anxiety items). The rates were as follows: Australia, 23 percent [40]; the Netherlands, 41 percent [32]; and Ireland, 58 percent [41]. In Sourander's [29] study of asylum-seeking families, 69 percent of the parents reported symptoms of nervousness in a semistructured interview.

*PTSD*

Six studies among non–help-seeking asylum seekers report findings regarding PTSD. The lowest level (1.6 percent) was from an analysis of the records of 122 consecutive asylum seekers who were screened after being dispersed to the north of England [28]. Using the MINI structured interview, Eytan et al. [20] found a PTSD rate of 24 percent. The same study observed a rate of 29 percent using clinical interviews (*Diagnostic and Statistical Manual of Mental Disorders,* Fourth Revision [DSVM-IV] criteria). Gerritsen, Bramsen, Devillé, van Willigen, Hovens, and van der Ploeg [32] observed a similar rate of PTSD in their random sample of 232 asylum seekers, with 28.1 percent reporting traumatic symptoms on the Harvard Trauma Questionnaire (HTQ) [32]. Two studies that used the CIDI reported PTSD rates of 37 percent, one in the Netherlands [33] and the other in Australia [40]. The highest level of PTSD observed among non–help-seeking groups was among African asylum seekers in Austria [26]. Using semistructured diagnostic interviews, 48 percent were cases of PTSD. This rate dropped to 34 percent using the clinician administered PTSD Scale.

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Table 1

**Empirical Studies of Mental Health Among Non–help-Seeking Asylum Seekers, 1988–2007**

| Study | Methods | Population | Country of asylum | Outcome measures | Prevalence rates (%) | | | Key findings |
|---|---|---|---|---|---|---|---|---|
| | | | | | Dep. | Anx. | PTSD | |
| [20] | Validation study of screening interview; convenience sample | 101 asylum seekers<br>59 Africa<br>37 Europe<br>5 Asia | Switzerland | MINI and clinical diagnostic interviews (DSM-IV) | 30.0/ 34.0[a] | — | 24.0/ 29.0[a] | |
| [26] | Validation study; convenience sample | 48 of 50 asylum seekers in subsample from West Africa | Austria | HSCL-25<br>HTQ<br>CAPS-1<br>Clinical interviews | — | — | 34.0/ 48.0[a] | • African subsample: HSCL-25 M = 0.95 (SD = 0.60); HTQ total M = 1.78 (SD = 0.52) |
| [27] (Study 2) | Cross-sectional survey; convenience sample | 79 asylum seekers<br>77 refugees<br>Turkey<br>Iran | The Netherlands | Semistructured interviews (DSM-III-R) | — | — | — | • Refugees at lower risk for PTSD than asylum seekers (odds ratio = 0.4) |
| [28] | Analysis of records; consecutive sample (recently dispersed) | 122 asylum seekers | England | Health screening interview | 9.0 | — | 1.6 | |
| [29] | Qualitative study; convenience sample | 10 asylum-seeking families (16 parents and 25 children)<br>Kosovo<br>Iraq<br>Afghanistan | Finland | Semi-structured interviews | 69.0 | 69.0 | — | • Difficulty in gaining refugee status was the major source of distress for the majority of parents<br>• Long asylum process with uncertainty about the future and fear of deportation caused enormous anxiety |

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|---|---|---|---|---|---|---|---|---|
| [31] | Postal survey (60% of estimated pool of Tamil asylum seekers) | 62 Sri Lankan Tamil asylum seekers<br>30 Tamil refugees and 104 Tamil immigrants | Australia | HSCL-25<br>HTQ | — | — | — | • No differences in distress levels between asylum seekers and refugees<br>• Asylum seekers reported higher levels of post-migration stress than refugees |
| [32] | Cross-sectional survey;<br>random sample | 232 asylum seekers<br>178 refugees<br>Afghanistan<br>Iran<br>Somalia | The Netherlands | HSCL-25<br>HTQ | 61.5 | 41.2 | 28.1 | • Asylum seekers reported higher levels of depression, anxiety and PTSD than refugees |
| [33–34] | Cross-sectional survey; random sample | 294 Iraqi asylum seekers<br>143 <6 months<br>151 >2 years | The Netherlands | CIDI 2.1 | 34.7 | 22.4 | 36.7 | • Overall psychiatric prevalence: <6 months 42%; >2 years 66.2%<br>• Higher risk of psychopathology for longer-staying group (odds ratio = 2.16)<br>• Risk factors for psychopathology included: female sex, higher age, lack of work, family issues, asylum procedure stress |
| [35] | Qualitative study; convenience sample | 23 female asylum seekers<br>East Timor | Australia | — | — | — | — | • Post-migration stressors included fear of deportation, inability to plan for future, boredom and social isolation |

(*continues*)



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Table 1 (*continued*)

| Study | Methods | Population | Country of asylum | Outcome measures | Prevalence rates (%) Dep. | Anx. | PTSD | Key findings |
|---|---|---|---|---|---|---|---|---|
| [31] | Postal survey (60% of estimated pool of Tamil asylum seekers) | 62 Sri Lankan Tamil asylum seekers<br>30 Tamil refugees and 104 Tamil immigrants | Australia | HSCL-25<br>HTQ | — | — | — | • No differences in distress levels between asylum seekers and refugees<br>• Asylum seekers reported higher levels of post-migration stress than refugees |
| [32] | Cross-sectional survey;<br>random sample | 232 asylum seekers<br>178 refugees<br>Afghanistan<br>Iran<br>Somalia | The Netherlands | HSCL-25<br>HTQ | 61.5 | 41.2 | 28.1 | • Asylum seekers reported higher levels of depression, anxiety and PTSD than refugees |
| [33–34] | Cross-sectional survey; random sample | 294 Iraqi asylum seekers<br>143 <6 months<br>151 >2 years | The Netherlands | CIDI 2.1 | 34.7 | 22.4 | 36.7 | • Overall psychiatric prevalence: <6 months 42%; >2 years 66.2%<br>• Higher risk of psychopathology for longer-staying group (odds ratio = 2.16)<br>• Risk factors for psychopathology included: female sex, higher age, lack of work, family issues, asylum procedure stress |
| [35] | Qualitative study; convenience sample | 23 female asylum seekers<br>East Timor | Australia | — | — | — | — | • Post-migration stressors included fear of deportation, inability to plan for future, boredom and social isolation |

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|---|---|---|---|---|---|---|---|---|
| [38–39] | Longitudinal survey; convenience sample | Time 1: 90 asylum seekers and 62 with secure legal status<br>64 Africa<br>23 E. Europe and former Soviet Union<br>3 Asia | Ireland | SCL-90-R | — | — | — | • 60% of asylum seekers above S0evels of distress than those with a secure legal status<br>• Persons who obtained a positive asylum outcome showed a significant decline in distress and post-migration stress scores |
| [40] | Cross-sectional survey; consecutive sample at community resource centre | 40 asylum seekers | Australia | HSCL-25<br>HTQ<br>CIDI-PTSD | 33.3 | 23.1 | 37.0 | • Loneliness and boredom associated with both anxiety and depression<br>• Main concerns were related to asylum process, with 81% expressing serious or very serious fears of being sent home |
| [41] | Cross-sectional survey; convenience sample | 43 asylum seekers<br>95% African | Ireland | HSCL-25 | 47.0 | 48.0 | — | • Main concerns: difficulty visiting home country; safety of family; delays in processing asylum applications; not being allowed to work; loneliness and boredom; discrimination |



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### *Psychological Distress*

Four studies of non–help-seeking asylum seekers report general levels of psychological distress. In an Australian study, 28.2 percent scored above the HSCL-25 total score cut-off [40]. Two other studies found considerably higher levels of distress. A Dutch study found a HSCL-25 distress prevalence of 68.1 percent [32]. A longitudinal survey in Ireland found that at baseline, 60 percent of the asylum seeker subsample scored above the Symptom Checklist-90-R (SCL-90-R) cut-off (global severity index >1.0) [39]. In a study of newly arrived asylum seekers in Switzerland, Loutan, Bollini, Pampallona, Bierens de Haan, and Gariazzo [43] administered a 16-item measure of psychological and somatic symptoms based on the HSCL-25, the HTQ, and clinical experience. Thirty-seven percent of the 573 asylum seekers had experienced at least one symptom of severe intensity over the previous week.

## *Prevalence Rates: Help-Seeking Populations*

### *Depression*

Six studies among help-seeking populations report depression prevalence rates, of which four are analyses of clinical records. The first analyzed records of 97 Kurdish asylum seekers from Turkey in the United Kingdom who were referred for medical evaluation after allegations of torture [44]. Almost all of the patients reported low mood but only 7 percent fulfilled the DSM-IV criteria for major depression. A similar finding was observed in a Danish study [30]. Hallas, Hansen, Staehr, Munk-Andersen, and Jorgensen [30] pointed out that when asylum seekers in Denmark need more than three specialist consultations for mental illness or five for physical illness, the referrals need to be approved by the Danish Immigration Service. The authors accessed 4,516 records referrals, of which 3,960 (88 percent) were recorded using the World Health Organization's International Classification of Diseases-10 (ICD-10) criteria. In total, there were 2,152 (54 percent) diagnoses of mental disorder, of which 9 percent were for depression. See Table 2 for a summary.

Two other studies that analyzed clinical records found higher levels of depression. Kennedy, Jerrard-Dunne, Gill, and Webb [45] examined the cases of asylum seekers who accessed an Irish psychiatric service over a two-year period. Of the 31 cases, 36 percent fulfilled the criteria for a DSM-III-R diagnosis of a moderate (23 percent) or severe (13 percent) depression episode. Piwowarczyk [46] examined the records of 134 consecutive asylum seekers who accessed a service for survivors of torture and trauma in the United States. The author reported that 96 percent suffered from some form of depressive disorder (DSM-IV criteria) at intake, of whom 75.4 percent met the criteria for major depression.

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Two studies that reported rates of depression among help-seeking asylum seekers were based on interviews. In a clinical study of 24 male Lebanese asylum seekers in Denmark (12 tortured and 12 untortured controls), 29 percent reported symptoms of depression [47]. Silove et al. [37] interviewed a consecutive sample of 33 East Timorese asylum seekers who attended a clinic for survivors of torture and trauma. Using the CIDI, they found that 53 percent met the criteria for major depression and an additional 10 percent had minor depression.

*Anxiety*

Among help-seeking populations, five studies report findings in relation to anxiety levels. Two studies using interviews based on DSM criteria observed a prevalence rate of 7 percent for GAD [44–45] whereas Piwowarczyk's [46] chart review study found no cases of GAD. Using the CIDI among 33 East Timorese asylum seekers, Silove et al. [37] found a prevalence rate of 37 percent for GAD. Hougen's [47] study of Lebanese asylum seekers found that 16.7 percent reported symptoms of anxiety.

*PTSD*

Among the six studies that report PTSD rates among help-seeking asylum seekers, there was a high degree of variability, with rates ranging from 14 percent to 82 percent. Surprisingly, the lowest PTSD rate (14 percent) comes from Kurdish survivors of torture [44]. In an analysis of clinical records in an Irish hospital, 29 percent met the DSM-III-R criteria for a PTSD diagnosis [45]. In a Norwegian study that also examined hospital records, 43.4 percent of the asylum seekers acutely admitted between 1995 and 2001 met either the ICD-9 or ICD-10 criteria for PTSD [48]. In a Danish study, 50.8 percent of the 2,120 asylum seekers referred to specialists regarding a mental disorder had an ICD-10 diagnosis of PTSD [30]. The highest rates of PTSD were among consecutive clients at centres for survivors of torture and trauma. The point prevalence rate of CIDI PTSD among 33 East Timorese asylum seekers in Australia was 73 percent [37]. In Piwowarczyk's [46] analysis of clinical records of mostly African asylum seekers, 82.1 percent met the DSM-IV criteria for PTSD [46].

***Correlates of Postmigration Mental Health***

*Intergroup Comparisons for Legal/Immigration Status*

Six studies compared asylum seekers and refugees in relation to mental health. One of these studies also included a comparison group of immigrants [31]. Only one study conducted comparisons between asylum seekers and the host population [49].

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Table 2

**Empirical Studies of Mental Health Among Help-Seeking Asylum Seekers, 1988–2007**

| Study | Methods | Population | Country of asylum | Outcome measure(s) | Prevalence rates (%) | | | Key findings |
|---|---|---|---|---|---|---|---|---|
| | | | | | Dep. | Anx. | PTSD | |
| [44] | Analysis of records | 97 Kurdish tortured asylum seekers from Turkey | England | Clinical interviews (DSM-IV) | 7.0 | 7.0 | 14.0 | • Almost all sample reported low mood and fatigue but did not fulfil other criteria for diagnosis of major depression |
| [28] | Analysis of records from 2 general practices; random sample of 67 of 335 records, and all 250 records in other practice | Study 1 (Adelaide Medical Centre): 67 asylum seekers; Study 2 (St Anthony's Health centre): 250 asylum seekers | England | Interviews with general practitioner | — | — | — | • Study 1: 11% had depression, schizophrenia or PTSD; 10% had been prescribed medication for a mental health problem<br>• Study 2: 6% on some sort of medication suggestive of mental illness; 8 on anti-depressants and 4 on treatment for depression/anxiety or anxiety |
| [30] | Analysis of records of referrals to medical specialists | 3,960 asylum seekers | Denmark | ICD-10 criteria | 9.0 | — | 50.8 | • Referrals for mental disorders increased with length of stay in asylum centres |
| [27] (Study 1) | Analysis of records | 331 asylum seekers; 148 refugees<br>Latin America<br>Western Asia | The Netherlands | ICD-9 and DSM-III-R criteria | — | — | — | • No difference between asylum seekers and refugees regarding risk for PTSD |
| [47] | Control-group design; no details of randomization | 24 asylum seekers from Lebanon (12 tortured and 12 untortured) | Denmark | Clinical examination | 29.2 | 16.7 | — | • Legal status insecurity is an extreme stressor<br>• Considerable use of minor tranquillisers |

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|---|---|---|---|---|---|---|---|---|
| [48] | Acute admission rates to a psychiatric hospital between 1995–2000 | 53 asylum seekers (and 45 refugees)<br>9 Africa<br>23 Asia<br>21 Middle East | Norway | ICD-10 criteria | — | — | 43.4 | • PTSD more frequent among asylum seekers (43.4%) vs. refugees (11%)<br>• High proportion of PTSD attributed to stresses of life in reception centres and risk of being expelled from the country |
| [45] | Analysis of records for psychiatric hospital | 31 asylum seekers<br>22 Africa, 8 Eastern Europe<br>1 Afghanistan | Ireland | DSM-III-R criteria | 36.0 | 7.0 | 29.0 | • Only 6% had an established psychiatric history prior to migration |
| [49] | Analysis of records in 2 general practices | 171 asylum seekers (comparison sample of 343 Irish citizens) | Ireland | ICD-10 criteria | — | — | — | • Asylum seekers were 5 times more likely to be diagnosed with a psychiatric illness than Irish citizens |
| [25] | Qualitative study; convenience sample of outpatients | 23 asylum seekers (and 3 refugees)<br>14 Kosovo, 11 Bosnia-Herzegovina, 1 Serbia | Switzerland | — | — | — | — | • Psychosomatic complaints included headaches (20/26), fatigue (12/26), nervousness (18/26), sleep disturbances (7/26) and anxiety (12/26)<br>• Major postmigration stressors were uncertainty about the future (14/26) and fear of expulsion (14/26) |
| [46] | Analysis of records; consecutive sample in centre for survivors of torture and trauma | 134 asylum seekers; 110 Africa, 6 Europe, 3 Middle East , 6 Americas | United States | DSM-IV criteria | 75.4 | 0.0 | 82.1 | • 69.4% major depression single episode<br>• 6% major depression recurrent |

(*continues*)



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Table 2 (*continued*)

| Study | Methods | Population | Country of asylum | Outcome measure(s) | Prevalence rates (%) Dep. | Anx. | PTSD | Key findings |
|---|---|---|---|---|---|---|---|---|
| [37] | Mixed methods; consecutive sample at centre for survivors of torture and trauma | 33 East Timorese asylum seekers | Australia | CIDI, HTQ, Prime-MD (depression and anxiety) | 53.0 | 37.0 | 73.0 | • 80% of sample met criteria for one or more psychiatric diagnosis<br>• 10% minor depression<br>• 64% had comorbid PTSD and depression<br>• Major postmigration stressors included fear of repatriation and separation from family |

*Notes*. CIDI = Composite International Diagnostic Interview; HTQ = Harvard Trauma Questionnaire; MINI = Mini International Neuropsychiatric Interview; Prime-MD = Primary Care Evaluation of Mental Disorders.

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Among non–help-seeking populations, two Dutch studies found evidence for poorer mental health among asylum seekers versus refugees. Gerritsen et al. [32] found that asylum seekers reported higher levels of depression, anxiety and PTSD symptoms (62 percent, 41 percent, and 28 percent, respectively) as compared with refugees (29 percent, 28 percent, and 11 percent) [32]. Hondius, van Willigen, Kleijn, and van der Ploeg [27] (Study 2) found a lower risk of PTSD among refugees (odds ratio [OR] = 0.4) versus asylum seekers. Ryan, Benson, and Dooley's [39] longitudinal study compared levels of distress among persons still in the asylum process and those who had obtained a secure legal status. Asylum seekers reported higher levels of SCL-90-R distress than the secure legal status group at baseline ($M = 1.26$ vs. $M = 0.81$) and follow-up ($M = 1.10$ vs. $M = 0.77$). The only persons to show a decrease in distress at follow-up were those who had obtained a secure legal status between the study phases. Silove, Steel, McGorry, and Mohan [31] compared Tamil asylum seekers, refugees and immigrants in relation to risk for poor mental health. No differences were observed between refugees and asylum seekers. However, compared with immigrants, asylum seekers were at higher risk for depression (OR = 3.8), anxiety (OR = 3.6), and PTSD symptoms (OR = 3.2).

Two studies among help-seeking populations compared asylum seekers and refugees in relation to mental health outcomes. Hondius et al. [27] (Study 1) found no differences in levels of PTSD between the two groups. However, in an analysis of records of acute psychiatric admissions in a Norwegian hospital, McMahon, Macfarlane, Avalos, Cantillon, and Murphy [48] observed a higher prevalence of PTSD among asylum seekers (43 percent) as compared with refugees (11 percent).

The only study to compare asylum seekers and the host population was an analysis of the records of two medical practices in Ireland [49]. It reported that asylum seekers ($n = 171$) were five times more likely to be diagnosed with a psychiatric illness than a comparison group of Irish citizens ($n = 343$). The study also found that asylum seekers were three times more likely to be diagnosed with anxiety than the comparison group. It is worth noting that a Norwegian study that is not included in the review (because the study sample partially overlaps with a later study included in the review (i.e., [48]) found that the relative risk for admission to a psychiatric hospital was significantly higher among asylum seekers as compared with Norwegians (OR = 8.8) [50].

*Postmigration Stress*

Ten studies give details of postmigration factors that are related to the mental health of asylum seekers. Of these, five studies conducted quantitative analyses of postmigration demands using Silove, Sinnerbrink, Field, Manicavasagar, and Steel's [40] Post-Migration Living Difficulties questionnaire or adaptations thereof. The 23-item instrument asks respondents to rate the seriousness of difficulties that asylum seekers commonly encounter. Silove et al. found that the main source of perceived stress among their sample of asylum seekers was fears of being sent home.

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Other major stressors were concerns about family members back home, delays in processing asylum applications, and unemployment. Concerns about loneliness and boredom were associated with higher levels of distress. In a later study, Silove et al. compared levels of postmigration stress among Sri Lankan Tamils with different legal statuses [31]. They found that asylum seekers reported higher levels of post-migration stress than coethnic refugees and immigrants.

Begley, Garavan, Condon, Kelly, Holland, and Staines [41] used the same postmigration stress instrument in an Irish context. The main concerns among their sample included difficulties visiting one's home country, the safety of family members back home, delays in processing asylum applications, not being allowed to work, discrimination, and loneliness and boredom. Another Irish study assessed postmigration stress using an instrument that was based on Silove et al.'s questionnaire [38–39]. The main concerns for asylum seekers related to family separation, not having a work permit, boredom, fear of deportation, and delays in processing asylum applications. The study found higher levels of postmigration stress among asylum seekers versus those with a secure legal status. It also found in longitudinal analyses that levels of postmigration stress dropped significantly for persons who received a positive asylum outcome between study phases.

Laban, Gernaat, Komproe, van der Tweel, and De Jong [34] conducted factor analyses on the postmigration stress measure developed by Silove et al. [31, 40]. They found that the strongest risk factors for psychopathology related to lack of work, family issues, and asylum procedure stress. They also found that living separated from children under the age of 18 was associated with poorer mental health.

Laban et al.'s [33] findings also suggest that a prolonged asylum procedure is detrimental to one's mental health. As previously noted, they recruited a random sample of recently arrived (<6 months) and longer-staying (>2 years) asylum seekers. The overall prevalence of psychiatric disorders was 42 percent in the first group and 66 percent in the second. A long asylum procedure showed an odds ratio of 2.16 for psychopathology. This finding is supported in a large-scale epidemiological study in Denmark [30], which showed that referrals for a psychiatric diagnosis increased significantly with length of stay in an asylum centre ($\beta = 5.7$).

Qualitative findings from four studies support the previous findings regarding the major sources of postmigration stress for asylum seekers. In interviews with 23 asylum seekers from East Timor, Rees [35, p. 96] found that fear of deportation and an inability to plan for the future "dangerously compromised" their psychological well-being. In interviews with 10 families, Sourander [29] observed that difficulty in obtaining refugee status was the major source of distress for the majority of parents. The asylum process caused uncertainty about the future and fear of deportation. Family separation was also a common source of distress. In Perron and Hudelson's [25] clinical study, the main causes of stress cited were uncertainties about the future and fear of expulsion. In a study among East Timorese asylum seekers, Silove et al. [37, p. 461] found that "prolonged feelings of insecurity and

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powerlessness were pervasive." The major difficulties were poor access to services, the constant fear of repatriation, and family separation.

## Discussion

This paper presents a 20-year review of research on the mental health of nondetained adult asylum seekers in Western countries. We find evidence from both qualitative and quantitative studies that asylum seekers are at risk of experiencing both high levels of stress and poor mental health in the postmigration environment. High rates of depression, anxiety, and PTSD were observed among both community and clinical samples. There is also evidence that mental health deteriorates over time as asylum seekers await an outcome but that it improves once a positive outcome is obtained.

Findings from non–help-seeking groups give us some indication of the general level of psychological and psychiatric needs among asylum seekers. Prevalence rates among non–help-seeking groups were generally very high. Studies using standardized instruments or clinical interviews among non–help-seeking asylum seekers observed rates of depression as high as 69 percent [29] and rates of anxiety as high as 69 percent [29]. The lowest rates of depressive symptoms (9 percent and 18.9 percent) and PTSD (1.6 percent) were reported in two studies in the United Kingdom, which used a general health screening interview among recently dispersed asylum seekers [28, 42]. Apart from the anomalous rate of 1.6 percent, PTSD rates ranged from 24 percent to 48 percent.

Within-study analyses found that asylum seekers are at equal or greater risk for poor mental health as compared with persons with refugee status. In their literature review Fazel, Wheeler, and Danesh [14] estimated PTSD and depression rates based on clinical interviews among community studies with samples of at least 200 participants. In these studies, 9 percent were diagnosed with PTSD and 5 percent with major depression. In the only study included in the current review that meets Fazel et al.'s criteria, the rates of both PTSD (36.7 percent) and depression (33.3 percent) were considerably higher [33]. The higher rates of PTSD observed among asylum seekers may be due to experiences of retraumatization during the asylum process [51]. This view is supported by the finding that levels of PTSD increased over time among asylum seekers [33]. In relation to the higher levels of depression observed among asylum seekers versus refugees, it is likely that these are rooted in the extremely stressful postmigration environment in which asylum seekers live.

On the whole, the prevalence rates observed in this review are considerably higher than those reported among general populations in Western countries. For example, the National Comorbidity Survey [52–53] in the United States observed the following lifetime prevalence rates: major depressive episode, 17.1 percent; GAD, 5.1 percent; and PTSD, 7.8 percent.

Among help-seeking asylum seekers, some studies found extremely high rates of distress or poor mental health. A study in the United States observed a rate of

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major depression of 75 percent [46]. Two studies observed PTSD rates greater than 70 percent [31, 46]. The lowest rate of depression (9 percent) was from an analysis of 3,960 records [30]. A possible explanation for the anomaly here is that for each case only one psychiatric diagnosis was registered. In the same study, the prevalence rate for PTSD was 51 percent. Among a population of forced migrants, it may have been more likely that they would receive a diagnosis of PTSD than depression. This explanation may also apply to the lower rates of nontrauma-related anxiety observed among help-seeking asylum seekers. One study reported no cases of GAD [46], and two other studies reported a rate of 7 percent [44–45]. On the whole, the findings from help-seeking populations support those from community studies regarding the high levels of distress and poor mental health among this population.

The most likely explanation for the poor levels of mental health among asylum seekers is that they are exposed to multiple potent stressors in a situation where coping resources are severely limited. We cannot assume that all asylum seekers have fled from persecution, but we do know that they have experienced the life event of migration. On top of the acculturative stress that ensues when seeking to adapt to an unfamiliar sociocultural environment, all asylum seekers experience legal status insecurity. This event brings with it a pervasive sense of uncertainty about the future and an inability to make plans. It also brings a fear of deportation—an act that would result in the loss of all resources invested in reaching the host country. In addition to these stressors, the research literature has identified a whole range of demands that asylum seekers routinely experience, including family separation, forced unemployment, financial strain, boredom, loneliness, and discrimination.

The key message from these findings is that the asylum procedure is inherently damaging to mental health. It is not possible to eliminate the stress of legal status insecurity, but it is possible to reduce it through speedier decisions on asylum applications. Forced unemployment, financial strain, and family separation are all stressors than can be tackled through appropriate policy changes.

The major threats to the validity of the findings of the review relate to (a) the possibility that asylum seekers may be motivated to exaggerate their experiences of distress and trauma and (b) methodological weaknesses within the body of research. Given that the validity of an asylum seeker's right to receive protection depends on his or her ability to convince the authorities during an interview that he or she has suffered persecution, asylum seekers could plausibly be motivated to exaggerate their personal suffering in other contexts, such as during medical visits, in meetings with social workers, or in research interviews. Hence, mental health research among asylum seekers could be affected by a self-serving bias. This bias can pose a problem when participants feel that they can gain something by responding in a certain manner. Although they were aware of this potential for bias, none of the researchers in the studies reviewed found evidence for it. Moreover, researchers in interview-based studies have been careful to emphasize to participants that their responses would have no bearing on their asylum outcome [39–40].

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The body of research on asylum seekers is smaller and less methodologically rigorous than that on refugees. In their review, Fazel et al. managed to locate data for almost 7,000 refugees from quantitative, interview-based studies of non–help-seeking refugees [14]. If we had applied the same inclusion criteria here, we would have data for less than 500 asylum seekers. The only studies of asylum seekers with large data sets are those that examine clinical records.

The small body of research on asylum seekers certainly reflects difficulties in accessing this population. However, it may also stem from reluctance on the part of governments and funding organizations to support research on a population comprised of persons who may end up leaving their host country either voluntarily or through deportation. To date, there have been no large-scale mental health interview-based surveys of asylum seekers that are comparable to studies such as Chung and Bemak's [54] survey of 2,483 refugees in the United States or Beiser and Hou's [55] study of the 10-year Canadian Refugee Resettlement Project.

Most of the interview-based research on asylum seekers consists of cross-sectional studies conducted among small and culturally heterogeneous convenience samples. The use of small nonprobability samples is due to a number of factors, including the lack of systematic lists of asylum seekers, fear and mistrust of authority figures, and high levels of linguistic diversity. Many of the large-scale studies of refugees in recent decades have focused on a limited number of linguistic groups from Southeast Asia. Hence, resources could be maximized in relation to the translation of research materials and the use of bilingual research assistants. Because asylum seekers come from many regions throughout the world, it is generally not possible for researchers to maximize resources in this way. In relation to the paucity of longitudinal research among asylum seekers, one of the problems is their high degree of geographical mobility. This stems from a number of factors, including policies of dispersal and efforts by asylum seekers to live nearer family members or coethnics.

Despite the shortcomings in the research literature on asylum seekers, we must acknowledge that a range of studies using a variety of methods in 10 different countries have found this population to be at risk for psychological suffering. We do not need sophisticated research to tell us that humans suffer in toxic social environments. The asylum process is by its very nature such an environment. What asylum seekers need urgently is not more research but a willingness on the part of their host societies to grant them basic human rights.

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